***Authorization for Release of Medical Information***

*Integrative Physiotherapy*
*Dr. John Kummrow*
Fort Collins, CO 80526

Patient's Name:_____ Date of Birth:_____

Address:_____

City/State/Zip Code:_____

SS#:_____ Patient's Phone #: _____

Date of Request: _____ Date Needed:_____

☐ I authorize Integrative Physiotherapy

to **release information to:**

_____
Name of Provider Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (Including Area Code)

☐ I authorize Integrative Physiotherapy

to **obtain information from:**

_____
Name of Provider Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (Including Area Code)

**PURPOSE FOR THIS REQUEST**: (Check one)

☐ Physician Follow- up ☐ Use by Law-Firm ☐ Other, specify: _____

**TYPE OF RECORDS REQUESTED**: (Check one)

☐ All Physical Therapy medical records; *or* ☐ Other, specify date range: _____

_____

**AUTHORIZATION VALID FOR**: (Check one)

☐ This request only.
☐ One year from date of this authorization OR _____days.
☐ This Authorization Applies to the records of the treatment received on or prior to the date of the authorization.
☐ This request and for medical records of any future treatment of the type described above until: _____ (insert date).

Signature (Patient): _____ Date: _____